

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(INCOMING RECORDS)

(Print Patient's full name)

Date of Birth

(Street Address)

Social Security number

(City, State, zip code)

Contact Phone Number

FROM: _____

Name of Facility / Doctor

Street address

City, State, zip code

Fax Number

TO: Bull Run Family Practice
8640 Sudley Road, Suite 203
Manassas, Virginia 20110
Phone: 703-368-3161
Fax: 703-368-2498

PROVIDER: _____

Appointment on _____

DATES of _____

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

____ OFFICE VIST NOTES ____ CARDIAC REPORTS ____ WELL CHILD CHECK UP
____ IMMUNIZATION RECORD ____ PATHOLOGY REPORTS ____ OTHER _____
____ LABORATORY REPORTS ____ OPERATIVE REPORT _____
____ RADIOLOGY REPORTS ____ COMPREHENSIVE PHYSICAL

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished my not condition its treatment of me on whether or not I sign the authorization.

SIGNATURE of Patient

Date

Return of Records Policy:

Upon the completion of the review of my records I request the following:

____ *I request my records be destroyed*

____ *Notify me via mail for pick up within 30 days.*

I understand any records not picked up within 30 days will be destroyed.